WOC Complex Plan of Care

Name: ____Sheila Guzman____ **Patient Encounter Date: __10/28/24__**

Preceptor for Patient Encounter: ___Christopher Eddun___

Clinical Focus: Wound __X__ Ostomy ____ Continence ____

Number of Clinical Hours Today: _16___

One complex journal is required for each specialty in which you are enrolled/registered. This assignment evaluates the transition from bedside nurse to that of a specialist/consultant. Critical thinking skills and understanding of evidence based, best practices should be evident. Rationales should be cited and referenced using current APA formatting.

Choose a patient from your clinical experience that exhibits multiple care needs allowing for development of an expanded, holistic plan of care. It is recommended this complex plan of care be your last journal for each specialty allowing for incorporation of previous instructor feedback. Reach out to your Practicum instructor for any questions.

Pertinent Medical/Nursing History	Pertinent lab/diagnostic test results
EP is a 43 yo female with h/o uterine fibroids. DNR status. Per husband, she had an appt on 7/22/24 at USA Vein Clinics and Fibroid Center on Fordham Rd, where she was diagnosed with uterine fibroids x 4 and found to be approximately 1 month pregnant. She received an injection of unknown type. Husband stated that the clinic told them they can't give other injections or do additional imaging on pregnant patients. After this appointment, EP traveled to Puerto Rico and returned two days prior to the ER admission. After her travel, the husband stated she was feeling tired and a day later developed chest pain which made her go to the ER. EP presented to the ER on 8/18 with chest pain, shortness of breath, hypoxia, tachycardia and shortly after arrival to ER went into cardiac arrest. She showed pulseless electric activity and asystole with high concerns for PE. ROSC was achieved after 12 rounds of CPR but lost shortly after. After an additional 39 mins of coding, ROSC was achieved, and she was placed on V/A ECMO via right groin. Course complications as follows: hemorrhagic shock due to lacerations of the liver that required ex-lap, s/p right colectomy of ischemic colon on 8/22/24, open abdomen s/p abdominal closure with Ventralex mesh on 8/24/24, AKI requiring CRRT which has resolved, gastro-pleural fistula which has resolved, s/p multiple endoscopic interventions and related empyema, s/p chest tube and Ertapenem which ended on 10/7/2 due to normalized WBC and chest tube with minimal residual collection, s/p tracheostomy, ileostomy and GT/JT placement. Per Neurology, prognosis for meaningful recovery is poor, due to hypoxic/ischemic brain injury evidenced by unresponsive wakefulness. Wakefulness and grimacing were thought to be due to anxiety. Grimacing has since improved but intermittent tachycardia continues despite ATC opioids and absence of stimulation. Low dose of Lexapro was started per Psychiatry 10/18. This makes it hard to identify pain, Pain management team is involved and has ordered preemptive	***Patient's family have requested to minimize blood draws to twice weekly*** **-LABS- 10/28/24** WBC= 10.78 HGB= 11.5 HCT= 37.1 RBC= 3.63 Platelets=285 Sodium= 151 Potassium=5.0 Chloride 115 Carbon dioxide= 19 BUN= 35 Creatinine=0.44 Glucose= 120 Calcium= 10.0

medication prior to cares and high stimulating activities.

WOC nurse was consulted by primary RN, who noted a wound on the right fleshy lumbar part of the back of this patient. EP laying in Citadel bed, on humidified room air via Tracheostomy. Trach area and dressings are clean, dry and intact. Patient appears to be awake but is unresponsive to voice or tactile stimulation. Abdomen is soft and non-distended, NPWT managed by Surgery is on, dressing is intact. Ileostomy pouch is intact, with moderate amount of loose yellow/brown stool. Stoma is round, red, and moist. Peristomal skin is clean, dry and intact. Indwelling foley catheter in place, draining dark yellow urine into bag. No edema noted on lower extremities. Lower extremities are pink and warm to touch, pulses present and equal bilaterally. Capillary refill less than 3secs. Tolerated turning on her side well.

Upon assessment of the right fleshy lumbar part of the back, a shallow, moist lesion with attached crusty edges noted. Scant amount of serous drainage noted. Area cleansed with NS, measured to be 4.5x3.2x0.2cm, and Mepilex foam dressing applied. Pt repositioned back supine position. Dressings removed from bilateral heels for assessment. Right heel DTPI that was initially noted on 9/18, has dry stable eschar, painted area with Betadine, measured 2x2x0.1cm, Mepilex foam dressing reapplied. Left heel is intact, no redness noted. Mepilex foam dressing reapplied. Heels offloaded with Z-flow booties. The left, lower helix part of the ear was previously an unstageable PI, also noted on 9/18, however necrotic tissue is now gone, displaying a moist, full thickness stage 3 PI and measuring 1.6x0.4x0.2cm. Ear was cleansed with NS and Mepilex foam dressing reapplied, offloaded with use of pt's pillow. Primary Nurse and medical team updated and told that this is natural wound progression and indicate healing. Education on prevention and proper care of tracheostomy, ostomy, NPWT, catheter care and CAUTI prevention re-enforced Patient left awake in bed in no apparent acute distress, pain or discomfort, no grimacing noted. Siderails up x4 for safety.

Scheduled medications:

- acetaminophen, 650 mg, Gastrostomy Tube, Q6 Hrs SCH
- carboxymethylcellulose ophthalmic solution, 1 drop, Both Eyes, Q6 Hrs SCH
- cefTRIAXone, 2 g, Intravenous, Q24 Hrs SCH
- chlorhexidine, 15 mL, Swab, Q12 Hrs SCH (0900-2100)
- enoxaparin, 70 mg, Subcutaneous, Q12 Hrs Sch (0900-2100)
- erythromycin ophthalmic ointment, 0.5 Inch, Both Eyes, 3X Day
- escitalopram, 5 mg, Gastrostomy Tube, Daily (0900)
- fluconazole, 200 mg, Gastrostomy Tube, Q24H
- iohexol, 500 mL, Jejunostomy Tube, Once
- lorazepam, 1 mg, Gastrostomy Tube, Q6 Hrs
- moxifloxacin ophthalmic solution, 1 drop, Both Eyes, 3X Day
- oxycodone, 5 mg, Gastrostomy Tube, Q6 Hrs
- pantoprazole, 40 mg, Gastrostomy Tube, Daily before Breakfast
- sodium chloride, 4 mL, Nebulization, Q6 Hrs SCH
- artificial tears ophthalmic ointment, 0.25 Inch, Both Eyes, Bedtime

Magnesium= 2.3
Phosphorus= 5.0

Urinalysis 10/26/24:
Appearance-Cloudy
Color- yellow
Specific gravity- 1.025
Bacteria- negative
UR Renal Epith Cell- 1
Squamous Epith Cells- 11
RBC urine- 9
WBC urine- 85
Yeast urine- present
Hyaline casts urine- 4
PH urine- 5.5
Protein urine- 100
Blood urine- moderate
Glucose- negative

-LABS- 9/18/24:
Cholesterol- 144
HDL- 18
LDL- 95
TRIG- 226
Hgb A1C- 5.1

Tube feedings: Formula-Osmolite 1.2 Cal (Cal Dense 1.2 Cal/mL); Standard Polymeric; Full Strength given via Gastrostomy Tube. NPO due to difficulty swallowing. Upon review of chart consults have been made by Primary care team: -As per Palliative Care Team notes, family knows that EP will never be the same but they are happy that she is still alive and have faith that she may still progress. Patient's mother reports that pt does track, has smiled and does move some facial muscles on command and that she cries with pictures of her children. Patient has 10yo twins, who keep asking for their mom and were told that she was "sleeping." Grandmother stated that one of the twins Googled it and said that he knows his mother was in a coma, not sleeping. -Thoracics follows CT scans of chest, noted gastropleural fistula to be resolved. No interventions currently. -Respiratory consulted and involved in care, recommend no capping at this time due to copious secretions. -Per PERT team, to continue with Lovenox therapeutic anticoagulation on discharge. -GI, Nutrition and Speech Therapy involved. NPO with EN support. Tolerating full TF via G/J-tube. - Urology consulted and stated renal failure has resolved and is now euvolemic. Concern for CAUTI. Urinary retention again, failed TOV with 650cc urinary retention. Foley replaced and plan to discharge with this given multiple episodes of retention. -Consulted GYN, no further evaluation or follow-ups indicated. - Surgical Team manages NPWT, continue changes as ordered on Monday/Thursday. ← *make sure there is indication of this in the POC.* - Continue PT/OT with preemptive analgesia -Social Worker and Case Manager working on discharge to Hospice Care. -Continue working with Pain Management and Psychiatric team. ** WOC nurse should be contacted with any questions and/or concerns about the dressings or changes in status of wounds.	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
*1. Shallow, moist lesion on fleshy, right lumbar side of the back	**1.** Cleanse with NS and pat dry with gauze. Cover with Mepilex silicone adhesive border foam dressing. Change 3x per week (every M,W,F) or if soiled or >70% saturated. Peel back dressing twice per day to assess skin. Offload by repostioning every 2hours, use AirTap positioner and wedges.	Notable decrease in wound size and drainage. Wound bed is pink and moist. Periwound skin is clean, dry and intact. Turning patient every 2 hours with use of offloading devices and skin assessments	Cleansing the wound will decrease the risk for infection, removes tissue that is necrotic, reduces bioburden and promotes healing (Wilkins et al., 2013). ← *use sources <5yo to back actions.* Alternative to using NS, is Vashe hypochlorous acid wound cleanser

*2. PI of left ear, lower helix part of pinna *3. Right heel DTPI with stable eschar **BRADEN SCORE:** Sensory perception- Completely limited (1) Moisture- Occasionally Moist (3) Activity- Bedfast (1) Mobility- Completely immobile (1) Nutrition- Adequated (3) Friction & Shear- Problem (1) TOTAL: 10= High risk for skin breakdown	**2.** Cleanse with NS, pat dry with gauze. Apply Mepilex silicone adhesive border foam dressing. Change 3 times per week (M,W,F) and if soiled. Peel back dressing twice per day to assess the skin. Offload with use of pt's pillow. **3.** Paint heel with Betadine. Cover with Mepilex silicone adhesive border foam dressing. Change 3 times per week (M,W,F) and if soiled. -Ensure bilateral heels are offloaded, utilize Z-flex boots. Assess heels and skin twice daily. -Do NOT debride right heel ulcer. ←*good* -Consult with PT/OT to provide exercises to increase mobility and blood circulation. Decreasing the risk for muscle deterioration, contractures, and pressure injuries. *Ok – rationale not needed in POC – include in last column.* -Consult with Dietician to manage a diet with necessary protein and nutrients necessary to promote healing and maintain immunity to help prevent/fight infection. *ok* -Coordinate a Family meeting with the team to communicate the holistic treatment plan, discuss realistic expectations and set goals. Educate family on wound care instructions.	charted. No new wounds or pressure injuries noted Healing wound base is pushing out eschar. ← *eschar noted covering less of wound.* Periwound skin is free of erythema, maceration and/or irritation. Pain is being managed appropriately, Pain Management team adjusting meds accordingly. Patient is being medicated prior to dressing changes. Patient is tolerating physical activities with assistance of PT/OT. Tolerating feedings. No nausea or vomiting reported. Family communicates being content with care being provided and feel supported and involved in care. Child life has coordinated dates for children to visit their mother.	because it is readily available at the hospital but potable water or other commercial cleansers for wounds can also be used. I would not recommend Dakin's solution on this wound (it's not available for use at this hospital), because it is mainly used for wounds that are necrotic, infected and that have a bad odor. Most commonly used concentration of 0.25%, is known to kill fibroblasts in clean wounds (Ramundo, 2022). *ok* Debridement is not recommended for this patient's heel, which is with dry, stable eschar and no signs of infection at this time. She is a palliative care patient and these patients are known to have impaired wound healing. The goal at this moment is not primarily to heal the wound. Our goals are to prevent further pressure injuries and/or infections and to provide comfort (Emmons et al, 2022). Nutrition plays an important role in the prevention of pressure injuries and in promoting its healing when a wound is present. Collaboration with Nutritionist/Dietician and Speech therapist is key to formulate a plan to provide optimal intake of necessary calories, vitamins and proteins that are key factors to decrease the risk for pressure injuries and for the wounds that are present to heal (Emmons et al, 2022). The patient is non-ambulatory and the wound does not appear infected, which are contraindications from debridement of the heels (Ramundo, 2022). OT/PT should be consulted and involved in mobilizing the patient as much as her condition permits. ← *why is*

	-Consult Pastoral, Psychological services for the family. Child Life to provide emotional support to the children. ← *child life is a good resource for both families and patients* **PRESSURE INJURY PREVENTION:** -Order Citadel 200 Specialty bed for active alternating pressure redistribution and enhanced microclimate management. -Turn and reposition the patient to offload pressure points every 2 hours as patient condition permits -Use one incontinence pad underneath the patient to minimize moisture and humidity, which can lead to skin breakdown. -Utilize AirTap positioner and wedges to ensure offloading of the sacrum. *ok* ** WOC nurse should be contacted if there are any changes in treatment plan, questions and/or concerns about the dressings or changes in status of wounds.		*this? Consider the science here* Mepilex silicone adhesive border foam dressing was selected because it is conformable, protective and non-adherent to wound bed. This will help minimize pain during skin assessments and dressing changes. Minimizing pain and providing comfort is a priority in all patients, especially those in her condition. It will absorb exudate coming from the wound. This dressing will protect the wound from further injury and from getting infected. Alternate dressing to Mepilex is using a hydrocolloid dressing such as Duoderm. This occlusive dressing is conformable and can absorb low amounts of drainage coming from the wound. Provides protection, moisture and aids in autolytic debridement (Jaszarowski et al, 2022). This dressing is appropriate for shallow wounds. This dressing requires gentle removal do to adhesive properties. Do not use as alternative for Mepilex on the heel with dry, stable eschar. *ok* Alternative to using patient's pillow is using a Z-flow pillow to offload. Turning and repositioning helps prevent or at least reduce the incidence of pressure injuries by redistributing pressure and enhancing blood flow to areas of high risk such as bony prominences or areas under medical devices (Asiri, 2023). This patient is at high risk for skin breakdown as evidenced by her medical history, Braden Score and inability to move or care for

			herself, making it our responsibility to provide the care for her. OT/PT and positioning team can play a very important part in assisting the Nurse, family and/or caregivers in achieving those goals.

References:

Asiri S. (2023). Turning and Repositioning Frequency to Prevent Hospital-Acquired Pressure Injuries Among Adult Patients: Systematic Review. *Inquiry : a journal of medical care organization, provision and financing*, *60*, 469580231215209. https://doi.org/10.1177/00469580231215209

Emmons, K. R. & Dale, B. A. (2022). Palliative wound care. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 776-792). Wolters Kluwer.

Jaszarowski, K & Murphree, R. W. (2022). Wound cleansing and dressing selection. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 157-168). Wolters Kluwer.

Ramundo, J. (2022). Principles and guidelines for wound debridement. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 172-186). Wolters Kluwer.

Wilkins, R. G., & Unverdorben, M. (2013). Wound cleaning and wound healing: a concise review. *Advances in skin & wound care*, *26*(4), 160–163. https://doi.org/10.1097/01.ASW.0000428861.26671.41

don't forget hanging indent.

WOC Complex Plan of Care

Content		Possible Points	Awarded Points	Comments
Summary of Selected Patient	Summarizes pertinent medical and surgical history	2	*2*	
Assessment	Describe assessment findings	6	*6*	
	List current products and interventions addressing WOC needs reflective of the specialty scope of practice (wound, ostomy, or continence)	6	*6*	
	Wound and Continence Case Study Journal: Using the Braden scale, assess for pressure injury risk. **You must submit your completed Braden risk assessment with your care plan.	5	*5*	
Planning	Formulate a comprehensive management plan based on the assessment and the specialty (wound, ostomy, or continence) needs. **Wound and Continence Case Study Journal:** Include specific Braden sub-scale scores	12	*10*	*Make sure NPWT alternative/management is noted in the plan – nursing might not manage, but may need to troubleshoot.* *hospice?*
	Propose alternative products. Include generic & brand names	4	*3*	*Noted for most products*
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	6	*5*	*This is present for most points*
Rationale	Explain the rationale for identified interventions	6	*4*	*maintain the specialist stance here – explain <u>why</u> you are directing as you do.*
Scholarly work	Rationales referenced & cited according to APA formatting guidelines	1	*1*	
	Proper grammar & punctuation used	1	*1*	
	References: See the course syllabus for specific requirements on references for all assignments	1	*1*	
	Total Points 80 % or higher is required to pass. Minimum scores: Ostomy: 36/45 Wound and Continence: 40/50		*43/50* *-1 resub*	

Additional comments:

~~*Hi Sheila – see my comments throughout and associated rubric. This submission is off to a good start, however needs some elaboration. This is a very complex case – make sure to maintain the role of the directing specialist and consider further holistic measures in your plan and rationale. The alternative component is missing for*~~

~~*your wound care interventions. Updates can be done right in this document and returned to drop box whenever complete. Reach out if you have any further questions or want to review any further concepts.*~~
~~*-Mike*~~

Hi Sheila – see my comments throughout. This revision of this assignment is much improved. Continue to apply the holistic approach to patient care and explore the reasoning "why" behind actions. You have reached the 80% threshold on this assignment and no further work is needed on it. Reach out with any further questions!
-Mike

Reviewed by: ____Mike Klements 11/6/2024_____ Date: ___11/6/24_____